STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 87763-001**
v

Blue Cross and Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 24th day of March 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On February 12, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on February 20, 2008.

The Commissioner notified Blue Cross and Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Office of Financial and Insurance Services received BCBSM's response on February 28, 2008.

The issue in this external review can be decided by a contractual analysis. The contract here is the BCBSM Community Blue Group Benefits Certificate (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

Petitioner underwent breast reconstruction and rhinoplasty surgery. These services were provided by a doctor who does not participate with BCBSM. BCBSM paid $3,104.43 toward the $9,872.00 charged by the surgeon.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on January 25, 2008 and issued a final adverse determination the same day.

III
ISSUE

Is BCBSM required to pay an additional amount for the surgical services provided to the Petitioner?

IV
ANALYSIS

Petitioner's Argument

The Petitioner is seeking payment of the full BCBSM approved amount for the repair of her facial fracture for a broken nose. This procedure was done at the same time as her post breast cancer reconstructive surgery. The Petitioner called about the procedure for the facial fracture to make sure it was a covered benefit. She was not told that it would only be covered at 50% because it was a second service performed at the same time.

The Petitioner knew that her surgeon charged more than participating providers, but no other surgeon was available to her. The surgeon that repaired her nose when she first broke it was terminally ill and unable to perform this follow-up surgery. Doing both the breast reconstruction and rhinoplasty procedures at the same time saved BCBSM hundreds, maybe a thousand, dollars or more, since there was only one hospital stay, one surgery room charge, one anesthesia, etc., not to mention less recovery time for the Petitioner.

The Petitioner argues that BCBSM should be required to pay 100%, not 50%, of its

approved amount for her rhinoplasty surgery.

BCBSM's Argument

BCBSM says it correctly paid for the services the Petitioner received from a nonparticipating provider.

Section 4 of the certificate, *Coverage for Physician and Other Professional Services,* explains how BCBSM pays nonparticipating providers. It says that BCBSM pays its "approved amount" for physician and other professional services – the certificate does not guarantee that charges will be paid in full. In addition, since the surgeon in this case does not participate with BCBSM, he is not required to accept BCBSM's approved amount as payment in full. The certificate also indicates that multiple surgeries performed on the same day by the same physician are paid according to national standards recognized by BCBSM.

The amounts charged by surgeon and the amounts paid by BCBSM for the November 8, 2006, surgeries are listed below:

Procedure Code	Nomenclature	Amount Charged	BCBSM's Approved Amount	Amount Paid by BCBSM
15734	Flaps (skin and/or deep tissue	$3,484.00	$1,548.2	$774.10**
19342	Mastectomy-repair	$2,084.00	$1,555.76	$1,555.76*
30410	Rhinoplasty	$4,304.00	$1,549.14	$774.57**
Totals		$9,872.00		$3,104.43

* Paid at full approved amount
** Paid at half of approved amount

BCBSM applied no deductible or co-payments to its approved amounts before it made its payment. It paid for the Petitioner's surgery based on the national standard that pays the full approved amount for the primary procedure and one half the approved amounts for any secondary procedures.

The maximum payment level for each service is determined by a resource based relative value scale (RBRVS), a nationally recognized reimbursement structure developed by and for physicians. The RBRVS reflects the resources required to perform each service, is regularly reviewed to address the effects of changing technology, training, and medical practice, and is adjusted by geographic region.

BCBSM contends that it has paid the proper amount for the Petitioner's care based on the national standard for multiple surgeries and is not required to pay more.

Commissioner's Review

The certificate explains that BCBSM pays an "approved amount" for physician and other professional services. The approved amount is defined in the certificate as the "lower of the billed charge or [BCBSM's] maximum payment level for a covered service." Participating and panel providers agree to accept the approved amount as payment in full for their services. Nonparticipating providers have no agreement with BCBSM to accept the approved amount as payment in full and may bill for the balance of the charges.

The certificate explains this (on pages 4.26 – 4.27):

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **NOTE**: Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM paid for the Petitioner's surgery based on the national standard that pays 100% of the approved amount for the primary procedure and 50% of the approved amount for any secondary procedures performed on the same day by the same surgeon. Nothing in the record establishes that BCBSM is required to pay an additional amount for this care.

It is unfortunate that the Petitioner was not able to use a participating provider. Nevertheless, there is nothing in the terms and conditions of the Petitioner's certificate that requires BCBSM to pay more than its approved amount (or 50% of the approved amount for secondary

procedures) to a nonparticipating provider, even if no participating provider was available.

Finally, the Petitioner believes that BCBSM failed to inform her in telephone conversations that it would pay only 50% of its approved amount for secondary procedures. Under PRIRA, the Commissioner's role is limited to determining whether a health plan has properly administered health care benefits under the terms and conditions of the applicable insurance contract and state law. Resolution of the factual dispute described by Petitioner cannot be part of a PRIRA decision because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

The Commissioner finds that BCBSM has paid the Petitioner's claims correctly according to the terms of the certificate and is not required to pay more for the Petitioner's care.

V
ORDER

BCBSM's final adverse determination of January 25, 2008, is upheld. BCBSM is not required to pay an additional amount for the Petitioner's surgery.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.